MDR Tracking Number: M5-04-3332-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on June 1, 2004.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the majority of the issues of medical necessity. The myofascial release, ice/heat therapy, electrical stimulation unattended, and ultrasound therapies from 06-11-03 through 10-01-03 were medically necessary. The office visits from 06-12-03 through 06-25-03 and the dispensed Biofreeze gel from 06-11-03 through 10-01-03 were not medically necessary. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20-days to the date the order was deemed received as outlined on page one of this Order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 07-14-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Max. Allowable Reimbursement)	Reference	Rationale
06-11-03	99213	$60.00	$0.00	N	$48.00	1996 Medical Fee Guideline	Requestor submitted relevant information that meets the documentation criteria for services billed. Recommend reimbursement of $48.00.
08-05-03	99213	$60.00	$0.00	D	$59.00	Medicare Fee Schedule	The requestor submitted relevant documentation to support services billed.

							Recommend reimbursement of $59.00.
08-05-03 10-01-03	99080-73 99080-73	$15.00 $15.00	$0.00	F F	$15.00 $15.00	Medicare Fee Schedule Rule 133.106 (f)(1)	TWCC-73 is a TWCC required report therefore, reimbursement for 99080-73 rendered on 08-05-03 and 10-01-03 is recommended in the amount of $30.00.
09-10-03	98940 99213	$45.00 $60.00	$0.00	F F	$30.14 $59.00	Medicare Fee Schedule	The requestor submitted relevant documentation to support services billed. Recommend reimbursement of $89.14.
09-10-03 09-12-03	97110 x 9 units	$360.00	$0.00	F	$32.64 x 9	Medicare Fee Schedule	See rationale below for CPT code 97110.
10-01-03	99211	$21.00	$0.00	Carrier did not deny w/code	$23.36	Medicare Fee Schedule	Requestor submitted relevant information to support services billed. Recommend reimbursement of $21.00.
TOTAL		$636.00					The requestor is entitled to reimbursement of $247.14.

Rationale for CPT code 97110- Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light all of the Commission requirements for proper documentation. The MRD declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy. Additional reimbursement not recommended.

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) and in accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202 (b); plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable for dates of service 06-11-03 through 10-01-03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 5th day of November 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

PR/pr

MEDICAL REVIEW OF TEXAS

[IRO #5259]
3402 Vanshire Drive Austin, Texas 78738
Phone: 512-402-1400 FAX: 512-402-1012

NOTICE OF INDEPENDENT REVIEW DETERMINATION

REVISED 8/5/04

TWCC Case Number:
MDR Tracking Number: M5-04-3332-01
Name of Patient:
Name of URA/Payer:
Name of Provider: (ER, Hospital, or Other Facility)
Name of Physician: (Treating or Requesting)

July 27, 2004

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

CLINICAL HISTORY

Patient is a 50-year-old male paramedic who, while working for the San Antonio Fire Department on ____, injured his lower back while lifting a patient onto a stretcher. He subsequently received chiropractic care with physical therapy, and then underwent epidural steroid injections and trigger point injections.

REQUESTED SERVICE(S)

Office visits (99213 and 99211) from 6/12/03 through 6/25/03, myofascial release (97250), ultrasound (97035), electrical stimulation, unattended (97014), ice/heat therapy (97010), and dispensed Biofreeze gel (E1399) for dates of service 06/11/03 through 10/01/03.

DECISION

The myofascial releases (97250), the ice/heat therapies (97010), the electrical stimulations, unattended (97014), the ultrasound therapies (97035) are approved.

All remaining treatments and procedures within the specified date range are denied.

RATIONALE/BASIS FOR DECISION

The medical records adequately established that this patient underwent an SI joint injection on 06/06/03 by Dr. H. The subsequent records very specifically reflected that Dr. H then ordered post-injection physical therapy to include these specific modalities for a total of seven visits. Further, the records also well established that the injection protocol was effective in

relieving the patient's symptoms and returning him to work. Therefore, the therapy during this time frame was medically necessary.

However, neither the diagnosis in this case nor the medical records submitted supported that it was medically necessary to perform an established problem-focused level of evaluation and management examination on each patient encounter. Also, the daily progress notes did not reflect that spinal manipulation was performed on these dates to otherwise necessitate this service. Therefore, most office visits (99213) are denied. But, on date of service 08/05/03, the records did reflect that the patient received a follow-up evaluation by the treating doctor, which was certainly appropriate in terms of the ongoing patient monitoring.